

Quality and Safety In Hospital Practice

2013

This position statement articulates the AMA view on:

- The importance of a focus of quality and safety in hospital practice;
- The essential components in providing a high quality and safe hospital; and
- The essential qualities and characteristics of a clinical governance system.

Background and Context

Australia has a high quality and accessible health system. In 2010–11 our hospital system provided 8.9 million hospital admissions – 5.3 million in public hospitals and 3.6 million in private hospitals. The vast bulk of medical training occurs in the public hospitals, developing medical students into fully trained medical practitioners.

Hospital care, particularly in the acute setting, is complex and involves risk. The clinical risks are unavoidably magnified by finite resources, the requirement to teach and train staff, and the obligation to accept all-comers.

Recent years have seen a move towards greater accountability and transparency of outcomes. There has been a substantial fall in peri-operative death rates through improved anaesthesia management, a substantial decline in death rates from heart attack and stroke, declining death rates from many cancers, improved diabetes management, improved options for mental health care, lower peri-natal and maternal death rates and longer life expectancy, amongst a multitude of improvements. (AIHW Australia's Health 2006, Chapter 2, pgs 15 to 129).

At the same time, our community has growing expectations and is more risk-averse. Public comment on many issues in health is overwhelmingly negative. This creates a public perception of a low quality health system riddled with adverse events and near misses, where litigation is the only form of redress available to patients.

The reality is that the Australian health system delivers a large number of cost-effective, high quality medical and health services. Despite the improvements, however, avoidable errors still occur, and ongoing improvements can be made. The community needs to have confidence that quality and safety are high priorities - not least because a health system constantly under unjustified attack will lead to more defensive medicine, which compromises both appropriateness and cost.

Quality and safety systems within hospitals should harness medical practitioners' continuous motivation to improve. Systems designed to improve quality and minimise risk should be guiding rather than restrictive by recognising skilled people as problem-solvers and by empowering them to make informed safety decisions.

The AMA recommends that quality and safety systems should be designed to:

- Utilise risk perception and real-world risk estimation and prioritisation by medical practitioners;
- Motivate excellent behaviours and not just punish errors;
- Move beyond incident reporting and root cause analysis;
- Incorporate understandings of cognitive analysis in risk-mitigation systems;
- Empower clinicians and managers as partners in governance and risk management; and
- Adopt standards for training and practice in clinical governance.

Requirements for an effective Quality and Safety System

- **Data**

The data collected to inform quality practice must be both robust and clinically relevant. Clinicians should be consulted in the method of data collection and indicators measured. Data must be easily accessible, delivered in a logical format, and up-to-date. Clinicians should not bear an unreasonable burden of data collection or data entry. All clinicians need adequate access to appropriate information technology.

- **Local Design and Relevance**

To be effective, the quality and safety system must have “buy-in” from local clinicians. While consistency of definitions is useful for comparison with peers, local relevance is a key to clinician engagement.

- **Philosophy of Improvement rather than Blame**

The quality cycle involves reviewing past practice, assessing results, implementing improved processes, and re-assessing results. The purpose of investigating errors or perceived failures must genuinely be to bring about improvement in performance – not to punish individuals.

- **Focus on Outcomes over Process**

While there are advantages to standardisation of processes in some areas of practice, a quality system must not allow the process to become the aim. Work processes should not be changed unless there is good evidence that the change will improve outcomes in a systematic way. Change should not be self-fulfilling or symbolic.

- **Acceptance of Reasonable Risk**

A quality and safety system must recognise that no human system will ever be 100% reliable or 100% safe. While attempts to reduce human error should be made (for example, reducing fatigue, simplifying complex processes), it must be recognised that unpredictable human error will never be eliminated.

Quality indicators must distinguish between known and expected complications and potentially preventable adverse events.

- **Action in Proportion to Risk**

Where the review of an adverse event suggests a change in policy or process, this should only occur where it is likely that the change will significantly improve safety. This means that major change should not occur to mitigate minor risk, and that the proposed change should not cause other unanticipated harm in a different area.

Incidents and risks should be investigated and resolved as close to the operational unit (ward, department) as possible.

- **Realistic Peer Comparisons**

Where quality and safety data are used to compare institutions, only peer hospitals should be directly compared. Account must be taken of factors like patient case-mix, hospital drainage population and resources.

Individual clinicians' performance should be assessed against their true peers, not an idealised standard.

Requirements for the Provision of High Quality and Safe Care

- **Resources**

Hospitals require clinical and support staff in adequate numbers and of appropriate skill and experience to provide safe and high quality care. A highly-trained medical workforce is essential, working to the best of their potential, and without excessive fatigue. Medical and other staff need to feel valued and respected. There must be adequate supervision for junior staff and medical students. All staff need adequate access to continuing education.

Hospitals also need to function with adequate bed capacity, equipment and facilities, including investigation departments, operating theatres and support services. There must be timely access to these facilities. The AMA recommends an average bed occupancy rate of 85% for safe practice.

- **Commitment and Culture**

Hospital managers and clinicians must collaborate with mutual respect to provide a safe and high-quality service. There must be broadly agreed aims and an agreement to collaborate. Values should be conjointly held and followed.

An organisation that values and recognises the skills of its employees will motivate them to achieve excellence rather than punish them for error. Organisations should encourage staff to interpret and apply procedures to match conditions, and to detect and correct things that go wrong.

- **Communication**

A reliable communication circuit must exist between the hospital and community services, particularly General Practitioners. Where feasible, discharge summaries should be contemporaneous. Appropriate and accessible information technology must exist for the generation and transmission of written communication between hospitals and healthcare providers in the community. Ideally hospital IT systems are able to interface with general practice systems.

The AMA supports open communication following an adverse event in health care and the principle of Open Disclosure, an approach which recognises the reality of human error and respects the patient's right to know what happened.

- **Medication Safety**

All aspects of medication ordering, dispensing and administration should be delivered in a system that is designed to minimise error.

- **Staff Safety**

Procedures and policies must exist to minimise harm to staff through work-place injury, assault, excessive fatigue and body fluid exposure, including needlestick injury.

- **Incident tracking and Investigation**

An easily accessible electronic system must exist to allow staff to report adverse events and near-misses. Managers must have access to reports from their own units, as well as summary data that identifies trends and emerging issues.

- **Performance Indicators**

Each institution should monitor a locally-relevant and realistically achievable set of indicators, and respond actively to identified gaps in performance.

- **Structured review**

Each hospital must have a formalised method for review of adverse events and near-misses. The methodology should be adaptable to the nature and severity of the incident, and should involve clinicians from the service where the incident occurred. Local guidelines should exist to guide the use of methods appropriate to the nature of the incident being investigated. Suitable methods may include (but are not limited to): morbidity and mortality meeting review, cause mapping, and Root Cause Analysis.

- **Action following incident review**

In general, any policy or practice change resulting from incident review should be proportional to the nature and magnitude of the incident. The new or altered procedure should be assessed for a significant chance of mitigating the risk, and should be screened for potential unintended harms, prior to considering implementation. Service heads should be integrally involved in the design and implementation of any new processes or policies affecting their service.

Characteristics of a Robust Clinical Governance System

- **Accountability**

Lines of accountability are clearly outlined. Individuals are only held accountable for factors that are reasonably within their control. A conjoint accountability relationship exists between managers and direct clinical care providers for collaborating to provide safe care.

- **Transparency**

Processes and policies for reporting, investigating and acting on different types of incidents and risks are clearly documented. Feedback is provided where possible at all levels (bearing in mind confidentiality issues).

- **Skill and Evidence**

Hospital care is a highly complex service. A system of governance should mirror the complexity and sophistication of the service it seeks to govern. Where possible, methodology used is based on evidence or has been validated. Local data is used to guide priorities for action. Clinical governance staff participate in ongoing training and education.

- **Quality in Clinical Governance**

The governance structure uses quality principles to continuously improve its own service. Data are collected to review the effectiveness of interventions. The service regularly conducts both internal and external audit and review. Regular feedback is sought from clinicians.

- **Leadership**

The Clinical Governance System executive team includes appropriate numbers of senior medical staff who can contribute both clinical knowledge and understanding of risk.

- **Resources**

Like the clinical service, the governance service requires adequate resources to function effectively. This includes adequate numbers of skilled staff, competent support staff, communication technology, equipment and space.

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